

Exhibit 3(g): Dey Labs

- J7613
- J7644

EVERETT, MA 02148	DEPENDENT (DEPENDENT)	RELATIONSHIP
PROVIDER ACCOUNT		Employee
59-3493196		

70

05/06/2005

Date Issued

Amount Paid: \$20.62

HOLBROOK, MA 02343

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Goodlettsville, TN 37070-1449

Claim No. 2890236

Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1412543

Explanation of Benefits

SMW+ Program

Date of Service	Amount	Non-Charges	Covered	Mar Med
From	To	Charged	Covered	Allowed
03/24/2005	03/24/2005	\$1,212.60	\$0.00	\$20.62
				\$20.62
				\$20.62

Total	\$1,212.60	\$0.00	\$20.62	\$20.62
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Comments:

Payment made to

LINCARE PHARMACY SERVICES
POB 9515
AMHERST, NY 14226

Provider: LINCARE PHARMACY SERVICES

Participant SSN:

SMG Claim Number: 2890236

/1

Processed by



Southern Benefit
Administrators, Inc.

HIGHLY CONFIDENTIAL
SMAHMASS 000470

PLEASE
DO NOT
STAPLE
IN THIS
AREA

6TN54

SHEET METAL WORKERS

APPROVED OMB-0938-0008

PO BOX 1449

GOODLETTSVILLE

TN 37070 1449

CARRIER

PATIENT AND INSURED INF

PHYSICIAN OR SUPPLIER INFORMATION

PICA J9541379

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX 02 28 1922 M F	
5. PATIENT'S ADDRESS (No., Street) CITY HOLBROOK STATE MA ZIP CODE 02343 1831 TELEPHONE (Include Area Code)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY HOLBROOK STATE MA ZIP CODE 02343 TELEPHONE (INCLUDE AREA CODE)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? 10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE		11. INSURED'S POLICY GROUP OR FECA NUMBER 496 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 19. RESERVED FOR LOCAL USE		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 20. OUTSIDE LAB? \$ CHARGES 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 496 2. 3. 4. 24. A DATE(S) OF SERVICE FROM TO B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE			
25. FEDERAL TAX I.D. NUMBER SSN EIN 593493196		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) P G GABUS COMPUTER GENERATED SIGNED 04 14 05 DATE		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 4825 140TH AVE NORTH CLEARWATER FL 33762	
		28. TOTAL CHARGE \$ 121260 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 20162	
		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # LINCARE PHARMACY 800 882 0001 PO BOX 9515 AMHERST NY 14226 PIN# 592852900 GRP#	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

90013329 J9541379

PLEASE PRINT OR TYPE
22. 32 PRI P/R: 1A000

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), APPROVED OMB-0720-0001 (CHAMPUS) 4/14/05 042247

HIGHLY CONFIDENTIAL
SMMAIAC 000477

Electronic Remittance Notice MEDICARE PART B
 HEALTHNOW NY, INC.
 P.O. BOX 6800
 WILKES BARRE PA 18773 6800
 Co: 90 Rg: 01 Ds: 33 Gr: 29 HINGHAM

Batch#: 04EE49 Prov#: 1219950001 Check#: 000000001011124 Check Date: 4/11/2005 Check Amt: 9027.72

DDS	PBS	NDS	Proc	Mod	Billed	Allowed	Deduct	Co Ins	RC	Amt	Prov Pd
NAME										AGE Y MDA MADI	
032405 To 032405	12	1	60371		75.00	57.00	.00	11.70	CD42	18.00	45.60 SUPP
032405 To 032405	12	300	J7613 KP		324.00	21.00	.00	4.20	CD42	303.00	16.80 SUPP
032405 To 032405	12	1	J7644 RQ		183.06	.00	.00	.00	CD57	183.06	.00 SUPP
									CD42	605.43	
032405 To 032405	12	93	J7644 RQ		630.54	25.11	.00	5.02	CD57	183.06	20.09 SUPP
									CD42	605.43	
REN: M25	H115										
PT RESP	20.62				CLAIM TOTALS	1212.60	103.11	.00	20.62	1897.98	82.49 NET
ADJ TO TOTALS: PREV PD	.00				INTEREST	.00	LATE FILING CHARGE	.00		NET	82.49

Exhibit 3(h): Fujisawa

- J3303
- J3302
- J3370
- J7507
- J1100
- J9000
- J9190
- J1580

REDACTED

EMPLOYEE

87-4
640

042489146

PATIENT ACCOUNT #
17165

NO 0438624

07/19/2002

DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY *****23DOLLARS AND 20CENTS**

DOLLARS \$ *****23. 20**

TO THE
ORDER
OFCHARLES A. BIRBARA M.D. INC.
26 QUEEN STREET

0438624

AUTHORIZED SIGNATURE

WORCESTER, MA 01610

NON NEGOTIABLE

AUTHORIZED SIGNATURE

SunTrust Bank, N.A.
Nashville, Tennessee 37203

#00438624# 1064000046# 7021390302#

SHEET METAL WORKERS' NATIONAL HEALTH FUNDP.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131SMW+ PROGRAM**EXPLANATION OF BENEFITS**

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
06/11/2002	06/11/2002	226.00	.00	23.20	23.20	23.20
		226.00	.00	23.20	23.20	23.20

NON-COVERED CODES:

COMMENTS:

REDACTED

PATRICIA, JOHN
51 PINE HILL RD

WORCESTER MA 01604

HFD CLAIM NUMBER: 1350522

Processed by



SOUTHERN BENEFIT

HIGHLY CONFIDENTIAL
SMWMASS 000969

PLEASE
DO NOT
STAPLE
IN THIS
AREA

SHEET METAL WORKERS
NATIONAL HEALTH TR FUND
P.O. BOX 1449
GOODLETTSVILLE TN 37070

PICA

HEALTH INSURANCE CLAIM FORM

PICA (ITEM 1)

<p>Worcester MA ZIP CODE 01604</p>		<p>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></p>		<p>CITY STATE</p>	
<p>OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p>		<p>EMPLOYER'S NAME OR SCHOOL NAME</p>		<p>INSURED'S POLICY GROUP OR FECA NUMBER</p>	
<p>OTHER INSURED'S POLICY OR GROUP NUMBER</p>		<p>EMPLOYMENT? (CURRENT OR PREVIOUS)</p>		<p>INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/></p>	
<p>OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/></p>		<p>AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>		<p>EMPLOYER'S NAME OR SCHOOL NAME</p>	
<p>EMPLOYER'S NAME OR SCHOOL NAME</p>		<p>OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>		<p>INSURANCE PLAN NAME OR PROGRAM NAME</p>	
<p>P.O. BOX 111 HINGHAM MA 02044</p>		<p>10d. RESERVED FOR LOCAL USE</p>		<p>SHEET METAL WORKERS</p>	
<p>INSURANCE PLAN NAME OR PROGRAM NAME</p>		<p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p>		<p>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</p>	
<p>MEDICARE</p>		<p>SIGNATURE ON FILE 07/03/02</p>		<p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete Item 8 a-d.</p>	
<p>14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</p>		<p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE- MM DD YY</p>		<p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</p>	
<p>17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</p>		<p>17a. I.D. NUMBER OF REFERRING PHYSICIAN</p>		<p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</p>	
<p>JOHN KELLY</p>		<p>19. RESERVED FOR LOCAL USE</p>		<p>20. OUTSIDE LAB? \$ CHARGES</p>	
<p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)</p>		<p>22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.</p>		<p>23. PRIOR AUTHORIZATION NUMBER</p>	
<p>1. 71596</p>		<p>3. 1</p>		<p>24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPST/ Family Plan I EMG J COB K RESERVED FOR LOCAL USE</p>	
<p>2. 72751</p>		<p>4. 1</p>		<p>1 06/11/02 06/11/02 11 2 20610 1 105.00 1 A67226</p>	
<p>3 06/11/02 06/11/02 11 1 J3303 1,2 16.00 4 A67226</p>		<p>25. FEDERAL TAX I.D. NUMBER SSN EIN</p>		<p>26. PATIENT'S ACCOUNT NO.</p>	
<p>042489146 <input type="checkbox"/> <input checked="" type="checkbox"/></p>		<p>17165</p>		<p>27. ACCEPT ASSIGNMENT? (For govt. claims, 008 only) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>28. TOTAL CHARGE \$ 226.00</p>		<p>29. AMOUNT PAID \$ 202.80</p>		<p>30. BALANCE DUE \$ 23.20</p>	
<p>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</p>		<p>32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)</p>		<p>33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #</p>	
<p>CHARLES A. BIRBARA, M.D.</p>		<p>26 QUEEN STREET</p>		<p>WORCESTER MA 01610</p>	
<p>SIGNED 07/03/02 DATE</p>		<p>PIN#</p>		<p>GRP# A67226</p>	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1214-0005 FORM OMB-1500

HIGHLY CONFIDENTIAL
SMW/MMASS 000070

NATIONAL HERITAGE INSURANCE COMPANY
 PROVIDER #: H11203
 CHECK/EFT #: 125778830

06/28/02

125778830 100000806
 CHARLES A BIRBARA MD INC
 PAGE #: 5 OF 13

MEDICARE
 REMITTANCE
 NOTICE

PERF	PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME	DUBRINO, CANDACE			HIC 027486844A		ACNY 02609800018900			ICN 0202168688180	ASG Y MOA NAO1 NAO7	
N01540	0612 061202 11		1	99242 25		110.00	91.81	0.00	18.36 CO-42	18.19	73.45
N01540	0612 061202 11		1	20610		105.00	70.39	0.00	14.08 CO-42	34.61	56.31
N01540	0612 061202 11		2	J3302		10.00	1.72	0.00	0.34 CO-42	8.28	1.38
PT RESP	32.78			CLAIM TOTALS		225.00	163.92	0.00	32.78	61.08	131.14
											131.14 NET

N01540	0611 061102 11		1	20610 7651		105.00					
N01540	0611 061102 11		4	J3303		16.00					
PT RESP	23.20			CLAIM TOTALS		226.00	115.99	0.00	23.20	110.01	8.32
											92.79 NET

N01540	0611 061102 11		1	20610		105.00	70.39	70.39	0.00 CO-42	34.61	0.00
N01540	0611 061102 11		1	20552 7651		105.00	32.51	29.61	0.58 CO-42	39.98	2.32
											32.51
N01540	0611 061102 11		1	20552 7651		105.00	32.51	0.00	6.50 CO-42	39.98	26.01
											32.51
N01540	0611 061102 11		6	J3302		30.00	5.16	0.00	1.03 CO-42	24.84	4.13
PT RESP	108.11			CLAIM TOTALS		345.00	140.57	100.00	8.11	204.43	32.46
											32.46 NET

N01540	0613 061302 11		1	99211		35.00	22.03	0.00	4.41 CO-42	12.97	17.62
N01540	0613 061302 11		1	J9260		25.00	4.51	0.00	0.90 CO-42	20.49	3.61
PT RESP	5.31			CLAIM TOTALS		60.00	26.54	0.00	5.31	33.46	21.23
				CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS							21.23 NET

N01540	0611 061102 11		1	99211		35.00	22.03	0.00	4.41 CO-42	12.97	17.62
N01540	0611 061102 11		1	J9260		25.00	4.51	0.00	0.90 CO-42	20.49	3.61
PT RESP	5.31			CLAIM TOTALS		60.00	26.54	0.00	5.31	33.46	21.23
											21.23 NET

N01540	0611 061102 11		1	99211		35.00	22.03	0.00	4.41 CO-42	12.97	17.62
N01540	0611 061102 11		1	J9260		25.00	4.51	0.00	0.90 CO-42	20.49	3.61
PT RESP	5.31			CLAIM TOTALS		60.00	26.54	0.00	5.31	33.46	21.23
				CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS							21.23 NET

N01540	0613 061302 11		1	20600		95.00	53.22	0.00	10.64 CO-42	41.78	42.58
N01540	0613 061302 11		1	20600 7651		95.00	26.61	0.00	5.32 CO-42	41.78	21.29
											25.61
N01540	0613 061302 11		1	20600 7651		95.00	26.61	0.00	5.32 CO-42	41.78	21.29
											25.61
PT RESP	21.28			CLAIM TOTALS		285.00	106.44	0.00	21.28	178.56	85.16
				CLAIM INFORMATION FORWARDED TO: EMPIRE BC/BS							85.16 NET

N01540	0613 061302 11		1	20552		105.00	65.02	0.00	13.00 CO-42	39.98	52.02
N01540	0613 061302 11		1	20552 7651		105.00	32.51	0.00	6.50 CO-42	39.98	26.01
											32.51
N01540	0613 061302 11		1	20552 7651		105.00	32.51	0.00	6.50 CO-42	39.98	26.01
											32.51
N01540	0613 061302 11		6	J3302		30.00	5.16	0.00	1.03 CO-42	24.84	4.13
PT RESP	27.03			CLAIM TOTALS		345.00	135.20	0.00	27.03	209.80	108.17
				CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS							108.17 NET

N01540	0611 061102 11		1	20552		105.00	65.02	0.00	13.00 CO-42	39.98	52.02
N01540	0611 061102 11		1	20552 7651		105.00	32.51	0.00	6.50 CO-42	39.98	26.01
											32.51
N01540	0611 061102 11		1	20552 7651		105.00	32.51	0.00	6.50 CO-42	39.98	26.01
											32.51
N01540	0611 061102 11		6	J3302		30.00	5.16	0.00	1.03 CO-42	24.84	4.13
PT RESP	27.03			CLAIM TOTALS		345.00	135.20	0.00	27.03	209.80	108.17
				CLAIM INFORMATION FORWARDED TO: JOHN HANCOCK							108.17 NET

N01540	0610 061002 11		1	99212		45.00	38.68	0.00	7.74 CO-42	6.32	30.94
PT RESP	7.74			CLAIM TOTALS		45.00	38.68	0.00	7.74	6.32	30.94
											30.94 NET

PROVIDER TAX ID. #: 042489146		PATIENT ACCOUNT #: 7342		87-4 640 M
SHEET METAL WORKERS' NATIONAL HEALTH FUND P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449				NO 0438625 07/19/2002 DATE ISSUED
*****8DOLLARS AND 11CENTS**				
TO THE ORDER OF		CHARLES A. BIRBARA M.D. INC. 26 QUEEN STREET WORCESTER, MA 01610		0438625
		AUTHORIZED SIGNATURE		
		NON NEGOTIABLE		
		AUTHORIZED SIGNATURE		
<small>Southern Bank, Nashville Nashville, Tennessee 37203</small> ⑈00438625⑈ ⑆064000046⑆ 7021390302⑈				

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131

SMW+ PROGRAM**EXPLANATION OF BENEFITS**

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
06/11/2002	06/11/2002	345.00	.00	8.11	8.11	8.11
		345.00	.00	8.11	8.11	8.11

NON-COVERED CODES:

COMMENTS:

CHARGES APPLIED TO YOUR MEDICARE PART B DEDUCTIBLE ARE NOT PAYABLE
UNDER THIS PLAN. \$100.00 WAS APPLIED.

REDACTED

FATICANTI, JOHN
51 PINE HILL RD

WORCESTER MA 01604

NFD CLAIM NUMBER: 1850523

Processed by

**SOUTHERN BENEFIT**

HIGHLY CONFIDENTIAL
SMW/MASS 000072

PLEASE
DO NOT
STAPLE
IN THIS
AREA

RED

SHEET METAL WORKERS
NATIONAL HEALTH FUND
P.O. BOX 1449
GOODLETTSVILLE TN 37070

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BILLING (SSN) <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>		PATIENT'S BIRTH DATE MM DD YY 03 14 37 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
CITY WORCESTER MA ZIP CODE 01604 TEL. ()		CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER 020289697A		12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
13. EMPLOYER'S NAME OR SCHOOL NAME P.O. BOX 111 HINGHAM MA 02044		14. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 07/03/02			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE		14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE JOHN KELLY		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 7265 2. 72142		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances), CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPST Family Plan I EMG J COB K RESERVED FOR LOCAL USE			
1 06 11 02 06 11 02 11 2 20610 1 105 00 1 A67226			
2 06 11 02 06 11 02 11 2 20552 2 105 00 1 A67226			
3 06 11 02 06 11 02 11 2 20552 2 105 00 1 A67226			
4 06 11 02 06 11 02 11 1 J3302 1,2 30 00 6 A67226			
5			
6			
25. FEDERAL TAX ID. NUMBER SSN EIN 042489146		26. PATIENT'S ACCOUNT NO. 9342	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. TOTAL CHARGE \$ 345 00	
29. AMOUNT PAID \$ 236 89		30. BALANCE DUE \$ 108 11	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) CHARLES A. BIRBARA,		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) CHARLES A. BIRBARA, M.D., INC 26 QUEEN STREET WORCESTER MA 01610	
SIGNED 07/03/02 DATE		PIN GRP A67226	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-80), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-2101 (CHAMPIUS)

HIGHLY CONFIDENTIAL
SMWMASS 000973

EMPLOYEE	DEPENDENT	RELATIONSHIP
		Employee
04-2103602	25217241 1	

70

REDACTED

11/02/2005

Date Issued

Amount Paid: \$531.64

MEDWAY, MA 02053

REDACTED

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Goodlettsville, TN 37070-1449

Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. 3093339

Check No. 1605648

Explanation of Benefits

SMW+ Program

Date of Service From	Date of Service To	Amount Charged	Non- Covered	Charges Allowed	Covered Paid	MediMed Paid
09/19/2005	09/19/2005	\$6,134.82	\$0.00	\$531.64	\$531.64	\$531.64

Total: \$6,134.82 \$0.00 \$531.64 \$531.64 \$531.64

Comments:

REDACTED

Payor/Provider

MILFORD REGIONAL MEDICAL CEN
14 PROSPECT ST
MILFORD, MA 01757

Provider:

MILFORD REGIONAL MEDICAL CENT

Participant SSN:

SMG Claim Number: 3093339

Processed by



Southern Benefit
Administrators, Inc.

HIGHLY CONFIDENTIAL
SMWMASS 000524

220090

109/30/2005

20051010 PAGE 6

PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NAR	OUTLIER AMT	REIMB RATE	ALLOR/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM #/CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROP COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=XX	HIC CHG=X TOB=XXX	CV LN	NCV L	COVD CHGS		MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
54	119	199418							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050917	0	1217.32	0.00	0.310	281.48	0.00
			050917	0	1.32	0.00	0.00	62.34	0.00
				0	0.00	0.00	79.17	855.35	0.31
				0	1216.00	0.00	0.00	0.00	281.48
55	11	271236							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050919	0	507.00	0.00	0.310	54.33	0.00
			050919	0	0.00	0.00	0.00	54.33	0.00
				0	0.00	0.00	0.00	452.67	0.31
				0	507.00	0.00	0.00	0.00	54.33
56	119	108625							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050829	0	451.00	0.00	0.310	72.21	0.00
			050829	0	0.00	0.00	0.00	46.28	0.00
				0	0.00	0.00	38.04	340.75	0.31
				0	451.00	0.00	0.00	0.00	72.21
57	119	168828							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050919	0	944.00	0.00	0.310	80.37	0.00
			050919	0	0.00	0.00	0.00	25.69	0.00
				0	0.00	0.00	44.73	818.90	0.31
				0	944.00	0.00	0.00	0.00	80.37
58	11	164905							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050919	0	62.00	0.00	0.310	17.04	0.00
			050919	0	0.00	0.00	0.00	17.04	0.00
				0	0.00	0.00	0.00	44.96	0.31
				0	62.00	0.00	0.00	0.00	17.04
59	11	113082							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050916	0	506.00	0.00	0.310	55.14	0.00
			050916	0	0.00	0.00	0.00	55.14	0.00
				0	0.00	0.00	0.00	450.86	0.31
				0	506.00	0.00	0.00	0.00	55.14
60	11	174913							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050917	0	3335.46	0.00	0.310	477.12	0.00
			050917	0	0.00	0.00	0.00	30.12	0.00
				0	0.00	0.00	265.57	2592.77	0.31
				0	3335.46	0.00	0.00	0.00	477.12
61	11	195913							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050919	0	440.00	0.00	0.310	57.90	0.00
			050919	0	0.00	0.00	0.00	57.90	0.00
				0	0.00	0.00	0.00	382.10	0.31
				0	440.00	0.00	0.00	0.00	57.90
62	119	116397							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050919	0	259.54	0.00	0.310	61.75	0.00
			050919	0	1.54	0.00	0.00	0.00	0.00
				0	0.00	0.00	20.98	175.27	0.31
				0	258.00	0.00	0.00	0.00	61.75
63	11	118237							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050919	0	6134.82	0.00	0.310	893.48	0.00
			050919	0	98.33	0.00	0.00	0.00	0.00
				0	0.00	0.00	531.64	4611.37	0.31
				0	6036.49	0.00	0.00	0.00	893.48
64	11	208279							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050920	0	178.00	0.00	0.310	14.79	0.00
			050920	0	0.00	0.00	0.00	14.79	0.00
				0	0.00	0.00	0.00	163.21	0.31
				0	178.00	0.00	0.00	0.00	14.79
65	11	210302							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050919	0	428.00	0.00	0.310	28.63	0.00
			050919	0	0.00	0.00	0.00	28.63	0.00
				0	0.00	0.00	0.00	399.37	0.31
				0	428.00	0.00	0.00	0.00	28.63
66	11	140279							
NAME CHG=QC	HIC CHG=HN TOB=131								
			050916	0	45.00	0.00	0.310	7.16	0.00
			050916	0	0.00	0.00	0.00	7.16	0.00
				0	0.00	0.00	0.00	37.84	0.31
				0	45.00	0.00	0.00	0.00	7.16

[REDACTED]	
[REDACTED]	Employee
05-0504251	

49

07/12/2004

Date Issued

[REDACTED]

Amount Paid: \$136.44

WORCHESTER, MA 01606

[REDACTED]

File Copy

This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Goodlettsville, TN 37070-1449

Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. 2575096

Check No. 1117117

Explanation of Benefits

SMW+ Program

Date of Service	Amount	Non-Covered	Charges	Covered	Member	
From	To	Charged	Covered	Allowed	Paid	
06/08/2004	06/08/2004	\$905.62	\$0.00	\$136.44	\$136.44	\$136.44

Total	\$905.62	\$0.00	\$136.44	\$136.44	\$136.44
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Comments:

[REDACTED]

[REDACTED]

PROCARE PHARMACY DIRECT INC
PO BOX 99794
CHICAGO, IL 60696

Provider:

PROCARE PHARMACY DIRECT INC

Participant SSN:

DMA Claim Number: 2575096

Processed by



Southern Benefit
Administrators, Inc.

PLEASE SHEET METAL WORKERS PLUS
DO NOT LOCAL 52 HEALTH WELFARE
STAPLE PO BOX 1449
IN THIS AREA
GOODLETTSVILLE, TN 37070-1449
LOCAL 63

HEALTH INSURANCE CLAIM FORM																																																																																																																																																				
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>																																																																																																																																																				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY 05 20 1956 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																				
4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																																																																				
7. INSURED'S ADDRESS (No., Street) CITY WORCESTER STATE MA ZIP CODE 01606 TELEPHONE (Include Area Code)																																																																																																																																																				
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																				
11. INSURED'S DATE OF BIRTH MM DD YY 05 20 1956 SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																				
12. EMPLOYER'S NAME OR SCHOOL NAME 13. INSURANCE PLAN NAME OR PROGRAM NAME 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 8 a-d.																																																																																																																																																				
15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE DATE 06/26/04																																																																																																																																																				
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																				
18. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES 0.00 19. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																				
20. PRIOR AUTHORIZATION NUMBER																																																																																																																																																				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 122.0 KIDNEY TRANSPLANT STATUS 2. 250.00 DN TYPE II W/O COMP NT ST U																																																																																																																																																				
<table border="1"> <thead> <tr> <th colspan="4">24. A DATE(S) OF SERVICE</th> <th colspan="2">B Place of Service</th> <th colspan="2">C Type of Service</th> <th colspan="2">D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th colspan="2">E DIAGNOSIS CODE</th> <th colspan="2">F \$ CHARGES</th> <th colspan="2">G DAYS OR UNITS</th> <th colspan="2">H EPSCOT Family Plan</th> <th colspan="2">I FANG</th> <th colspan="2">J COB</th> <th colspan="2">K RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>06</td> <td>08</td> <td>04</td> <td></td> <td></td> <td></td> <td>12</td> <td>9</td> <td>00591-5052-10</td> <td>7506</td> <td>1</td> <td>9.99</td> <td>30</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>06</td> <td>08</td> <td>04</td> <td></td> <td></td> <td></td> <td>12</td> <td>9</td> <td>00004-0260-43</td> <td>7517</td> <td>1</td> <td>391.27</td> <td>120</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>06</td> <td>08</td> <td>04</td> <td></td> <td></td> <td></td> <td>12</td> <td>9</td> <td>00469-0617-73</td> <td>7507</td> <td>1</td> <td>504.36</td> <td>120</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>06</td> <td>08</td> <td>04</td> <td></td> <td></td> <td></td> <td>12</td> <td>9</td> <td>00469-0617-73</td> <td>7507</td> <td>1</td> <td>504.36</td> <td>120</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>										24. A DATE(S) OF SERVICE				B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSCOT Family Plan		I FANG		J COB		K RESERVED FOR LOCAL USE		MM	DD	YY	MM	DD	YY																		06	08	04				12	9	00591-5052-10	7506	1	9.99	30											06	08	04				12	9	00004-0260-43	7517	1	391.27	120											06	08	04				12	9	00469-0617-73	7507	1	504.36	120											06	08	04				12	9	00469-0617-73	7507	1	504.36	120										
24. A DATE(S) OF SERVICE				B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSCOT Family Plan		I FANG		J COB		K RESERVED FOR LOCAL USE																																																																																																																														
MM	DD	YY	MM	DD	YY																																																																																																																																															
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06	08	04				12	9	00469-0617-73	7507	1	504.36	120																																																																																																																																								
06	08	04				12	9	00469-0617-73	7507	1	504.36	120																																																																																																																																								
25. FEDERAL TAX I.D. NUMBER SSN EIN 050504251 <input type="checkbox"/> <input checked="" type="checkbox"/>																																																																																																																																																				
26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																																																																																																																				
28. TOTAL CHARGE \$ 905.62 29. AMOUNT PAID \$ 769.18 30. BALANCE DUE \$ 136.44																																																																																																																																																				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) MIKE ZEGLINSKI RPH SIGNED 06/26/2004 DATE																																																																																																																																																				
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) PROCARE PHARMACY DIRECT, INC 600 PENN CENTER BLVD PITTSBURGH, PA 15235-5810 (412) 824-2487																																																																																																																																																				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PROCARE PHARMACY, INC. PO BOX 99794 CHICAGO, IL 60696 (412) 824-2487 PIN # 3958898 GRP #																																																																																																																																																				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE SWS)
ATTACHMENTS: 11

PLEASE PRINT OR TYPE
06/26/2004

APPROVED CMB-0020-0006 FORM CMS-1500 (12-90), FORM HBB-1500,
APPROVED CME-1215 FORM OWCP-1500, APPROVED CMB-0720-001 (CHAMPUS)
COMMERCIAL - MAJOR MEDICAL/INDEMNITY

HIGHLY CONFIDENTIAL
SMW/MASS 000353

2-005909-04174-G498704Z-00811-T-01-05239

HealthNow New York Inc.
 Provider #: 1272330002
 Check/EFT #: 00000001741658

06/22/04

PROCARE PHARM DIRECT INC
 Page #: 004 of 005

MEDICARE
 REMITTANCE
 NOTICE

PERF	PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
1272330002	0608	060804	12	450	J7507	84.94	49.95	0.00	9.99	CO-42	14.99
PT RESP	9.99										39.96
ADJ TO TOTALS: PREV PD	0.00										39.96
CLAIM INFORMATION FORWARDED TO: HDM CORPORATION											

1272330002	0608	060804	12	450	J7507	1864.99	1408.50	0.00	281.70	CO-42	456.49
PT RESP	281.70										1126.80
ADJ TO TOTALS: PREV PD	0.00										1126.80
LATE FILING CHARGE 0.00 NET 1126.80											

1272330002	0609	060904	12	60	J7506	890.38	658.50	0.00	151.70	CO-42	231.88
PT RESP	131.70										526.80
ADJ TO TOTALS: PREV PD	0.00										526.80
LATE FILING CHARGE 0.00 NET 526.80											

1272330002	0609	060904	12	60	J7506	387.74	280.80	0.00	56.16	CO-42	106.94
PT RESP	56.16										224.64
ADJ TO TOTALS: PREV PD	0.00										224.64
LATE FILING CHARGE 0.00 NET 224.64											

1272330002	0524	052404	12	30	J7506	9.99	0.60	0.00	0.12	CO-42	9.39
PT RESP	0.24										0.48
ADJ TO TOTALS: PREV PD	0.00										0.96
LATE FILING CHARGE 0.00 NET 0.96											

NAME	H	ACNT	ICN	Y	MOA	MA01
1272330002	0608	060804	12	30	J7506	9.99
1272330002	0608	060804	12	120	J7507	504.26
1272330002	0608	060804	12	120	J7517	390.80
PT RESP	136.44					905.82
ADJ TO TOTALS: PREV PD	0.00					905.82
LATE FILING CHARGE 0.00 NET 545.76						

1272330002	0520	052004	12	24	J7506	24.80	0.48	0.00	0.10	CO-42	24.32
PT RESP	0.10										0.38
ADJ TO TOTALS: PREV PD	0.00										0.38
LATE FILING CHARGE 0.00 NET 0.38											

1272330002	0527	052704	12	120	J7520	1023.14	765.60	0.00	153.12	CO-42	257.54
PT RESP	153.12										612.48
ADJ TO TOTALS: PREV PD	0.00										612.48
LATE FILING CHARGE 0.00 NET 612.48											

1272330002	0609	060904	12	15	J7500	23.64	16.65	0.00	3.33	CO-42	6.99
PT RESP	3.57										13.32
ADJ TO TOTALS: PREV PD	0.00										14.28
LATE FILING CHARGE 0.00 NET 14.28											

1272330002	0609	060904	12	90	J7515	147.43	105.30	0.00	21.06	CO-42	42.13
PT RESP	49.14										84.24
ADJ TO TOTALS: PREV PD	0.00										196.56
LATE FILING CHARGE 0.00 NET 196.56											

1272330002	0607	060704	12	60	J7506	85.58	66.60	0.00	13.32	CO-42	18.98
PT RESP	13.32										53.28
ADJ TO TOTALS: PREV PD	0.00										53.28
LATE FILING CHARGE 0.00 NET 53.28											

1272330002	0607	060704	12	30	J7506	158.55	115.56	0.00	23.11	CO-42	42.99
PT RESP	23.11										92.45
ADJ TO TOTALS: PREV PD	0.00										92.45
LATE FILING CHARGE 0.00 NET 92.45											

1272330002	0607	060704	12	30	J7506	9.99	0.60	0.00	0.12	CO-42	9.39
PT RESP	0.12										0.48
ADJ TO TOTALS: PREV PD	0.00										0.48
LATE FILING CHARGE 0.00 NET 0.48											

04-3296910	Employee
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12/01/2001

Date Issued

REDACTEDAmount Paid: **\$40.95**

HANOVER, MA 02339

File Copy

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SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Goodlettsville, TN 37070-1449

Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **1618975**Check No. **0142626****Explanation of Benefits****SMW+ Program**

Date of Service	Amount Charged	Amount Covered	Amount Allowed	Amount Paid	Amount Due
10/09/2001	10/09/2001	\$309.00	\$0.00	\$40.95	\$40.95

Comments:

COMMONWEALTH HEMATOLOGY O
10 WILLARD ST
QUINCY, MA 02169

Provider: **COMMONWEALTH HEMATOLOGY ON**
Participant SSN: _____
DMA Claim Number: **1618975**

Processed by



Southern Benefit
Administrators, Inc.

REDACTED

IN THIS AREA
GOODLETTSVILLE TN 37070

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>									
2. PATIENT'S NAME (Last, First, Middle Initial) REDACTED									
3. PATIENT'S BIRTH DATE 12/04/1935 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
4. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
5. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input checked="" type="checkbox"/>									
6. EMPLOYMENT (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
7. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
8. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
9. INSURED'S DATE OF BIRTH REDACTED SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F									
10. EMPLOYER'S NAME OR SCHOOL NAME REDACTED									
11. INSURANCE PLAN NAME OR PROGRAM NAME REDACTED									
12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 11/09/01									
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 11/09/01									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 11/09/01 TO 11/09/01									
17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11/09/01 TO 11/09/01									
18. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
19. MEDICAID RESUBMISSION CODE 162.9 NEOPLASM LUNG									
20. PRIOR AUTHORIZATION NUMBER									
21. DATE(S) OF SERVICE FROM 10/09/01 TO 10/09/01									
22. PLACE OF SERVICE 3 90									
23. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) J7050									
24. DIAGNOSIS CODE 1									
25. \$ CHARGES 40 00									
26. DAYS OR UNITS 4									
27. EPSDT Family Plan 10									
28. EMG 2									
29. COB 3									
30. RESERVED FOR LOCAL USE									
31. FEDERAL TAX I.D. NUMBER 04-3296910 SSN EIN <input checked="" type="checkbox"/>									
32. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JAMES EVERETT, M.D.									
33. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) REDACTED									
34. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE COMMONWEALTH HEM-ONC 10 WILLARD STREET QUINCY MA 02169									
35. PIN# GRP#									
36. TOTAL CHARGE \$ 292 00									
37. AMOUNT PAID \$ 251 05									
38. BALANCE DUE \$ 40 95									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

 APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500,
 APPROVED OMB-1216-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

SECOND INSURANCE

 HIGHLY CONFIDENTIAL
 CMAA/MACS 001222

NATIONAL HERITAGE INSURANCE COMPANY
 PROVIDER #: M20160
 CHECK/EFT #: 125170270

10/29/01

125170270 100002167
 COMMONWEALTH HEMATOLOGY
 PAGE #: 3 OF 10

MEDICARE
 REMITTANCE
 NOTICE

PERF PROV SERV DATE POS NMS ICD9 CODE MONS BILLING ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD

NAME: J23017 1009 100901 11 4 J7050 36.36 0.00 7.27 CO-42 3.64 29.09
 J23017 1009 100901 11 10 J1260 230.00 0.00 32.90 CO-42 65.50 131.60
 J23017 1009 100901 11 2 J1200 4.00 0.00 0.20 CO-42 2.98 0.82
 J23017 1009 100901 11 3 J1100 18.00 0.00 0.58 CO-42 15.09 2.33
 J23017 1009 100901 11 1 85024 17.00 0.00 0.00 CO-42 5.30 11.70
 PT RESP 40.95 CLAIM TOTALS 309.00 216.49 0.00 40.95 92.51 175.54
 175.54 NET

NAME: J12474 0927 092701 22 1 99214 114.00 59.38 0.00 11.88 CO-B6 54.62 47.50
 PT RESP 11.88 CLAIM TOTALS 114.00 59.38 0.00 11.88 54.62 47.50
 CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS 47.50 NET

NAME: J09389 1010 101001 11 1 85024 17.00 11.70 0.00 0.00 CO-42 5.30 11.70
 PT RESP 0.00 CLAIM TOTALS 17.00 11.70 0.00 0.00 5.30 11.70
 11.70 NET

NAME: J09389 1010 101001 11 1 99214 114.00 87.78 0.00 17.56 CO-42 26.22 70.22
 J09389 1010 101001 11 1 96410 93.00 74.70 0.00 14.94 CO-42 18.30 59.76
 J09389 1010 101001 11 2 96412 166.00 110.62 0.00 22.12 CO-42 55.38 88.50
 J09389 1010 101001 11 6 99310 3732.00 2727.30 0.00 545.46 CO-42 1004.70 2181.84
 J09389 1010 101001 11 1 J1200 2.00 0.51 0.00 0.10 CO-42 1.49 0.41
 PT RESP 600.18 CLAIM TOTALS 4107.00 3000.91 0.00 600.18 1106.09 2400.73
 CLAIM INFORMATION FORWARDED TO: EMPIRE BC/BS 2400.73 NET

NAME: J09389 1010 101001 11 1 60001 10.00 3.00 0.00 0.00 CO-42 7.00 3.00
 PT RESP 0.00 CLAIM TOTALS 10.00 3.00 0.00 0.00 7.00 3.00
 3.00 NET

NAME: J02033 1011 101101 11 1 99213 73.00 56.41 0.00 11.28 CO-42 16.59 45.13
 J02033 1011 101101 11 1 85023 20.00 11.71 0.00 0.00 CO-42 8.29 11.71
 J02033 1011 101101 11 1 60001 10.00 3.00 0.00 0.00 CO-42 7.00 3.00
 PT RESP 11.28 CLAIM TOTALS 103.00 71.12 0.00 11.28 31.88 59.84
 59.84 NET

NAME: J05964 0917 091701 32 1 99312 76.00 57.89 0.00 11.58 CO-42 18.11 46.31
 J05964 0918 091801 32 1 99311 46.00 36.09 0.00 7.22 CO-42 9.91 28.87
 PT RESP 18.80 CLAIM TOTALS 122.00 93.98 0.00 18.80 28.02 75.18
 75.18 NET

NAME: J23017 1009 100901 11 1 99214 114.00 87.78 0.00 17.56 CO-42 26.22 70.22
 J23017 1009 100901 11 1 90782 7.00 0.00 0.00 0.00 CO-B15 7.00 0.00
 PT RESP 17.56 CLAIM TOTALS 121.00 87.78 0.00 17.56 33.22 70.22
 CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO 70.22 NET

NAME: J23017 1009 100901 11 1 85024 17.00 11.70 0.00 0.00 CO-42 5.30 11.70
 J23017 1009 100901 11 1 60001 10.00 3.00 0.00 0.00 CO-42 7.00 3.00
 J23017 1009 100901 11 30 00136 468.00 367.80 0.00 73.56 CO-42 100.20 294.24
 PT RESP 73.56 CLAIM TOTALS 495.00 382.50 0.00 73.56 112.50 308.94
 CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO 308.94 NET

NAME: J23017 0925 092501 11 1 J3490 CC 10.00 3.15 0.00 0.63 CO-42 6.85 2.52
 PT RESP 0.63 CLAIM TOTALS 10.00 3.15 0.00 0.63 6.85 2.52
 CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO 2.52 NET

NAME: B49039 0929 092901 21 1 99254 210.00 160.85 0.00 32.17 CO-42 49.15 128.68
 B49039 0930 093001 21 1 99231 50.00 39.08 0.00 7.82 CO-42 10.92 31.26
 PT RESP 39.99 CLAIM TOTALS 260.00 199.93 0.00 39.99 60.07 159.94
 CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS 159.94 NET

NAME: A28399 0921 092101 22 1 99214 114.00 59.38 0.00 11.88 CO-B6 54.62 47.50
 PT RESP 11.88 CLAIM TOTALS 114.00 59.38 0.00 11.88 54.62 47.50
 47.50 NET

PLEASE
DO NOT
STAPLE
IN THIS
AREA

MAIL TO:

SHEET METAL WORKERS NAT'L HEA
P O BOX 1449
GOODLETTSVILLE, TN 37070

APPROVED OMB-0538-0008

RETURN
SMWN 0001
00113
SECONDARY

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA OTHER					1a. INSURED'S ID. NUMBER (FOR PROGRAM IN ITEM 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX				
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED				
CITY STATE ZIP CODE TELEPHONE (Include Area Code)					7. INSURED'S ADDRESS (No., Street)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS)				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX					b. AUTO ACCIDENT? PLACE (State) DATE (MM/DD/YY) EMPLOYER'S NAME OR SCHOOL NAME				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
SIGNED SIGNATURE ON FILE DATE 11-17-03					SIGNED SIGNATURE ON FILE				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN				
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)					20. OUTSIDE LAB? \$ CHARGES				
1. 174.9					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
2. 1288.0					23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE From To B. Place of Service C. Type of Service D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS CODE					F. \$ CHARGES G. DAYS OF SERVICE H. EPSDT OR Family Plan I. EMG J. COB K. RESERVED FOR LOCAL USE				
1. 02/02/04 02/02/04 11 1 J9070					88.00 11				
2. 02/02/04 02/02/04 11 1 J1100					50.00 10				
3. 02/02/04 02/02/04 11 1 J9000					62.00 11				
4. 02/02/04 02/02/04 11 1 J7020					34.00 3				
5. 02/03/04 02/03/04 11 1 90782					30.00 1				
6. 02/03/04 02/03/04 11 1 T2505					3688.00 1				
25. FEDERAL TAX ID. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.				
04-3498186					27. ACCEPT ASSIGNMENT? (For govt. claims, see back)				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
HETZEL, PAUL M.D.					SPRINGFIELD MEDICAL ASSOC				
LIC.# 039373 03/04/04					2150 MAIN ST, STE 1000				
CONSULTED GENERAL					SPRINGFIELD, MA 01104-000				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE					34. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE				
SPRINGFIELD MEDICAL ASSOC					SPRINGFIELD MEDICAL ASSOC				
P.O. BOX 219					P.O. BOX 219				
WINDSOR, CT 06095-0000					WINDSOR, CT 06095-0000				
PIN#					GRP#				

MC (APPROVED BY AMO) 03/04/2004 0001842

PLEASE PRINT OR TYPE

APPROVED OMB-0538-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0027 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

HIGHLY CONFIDENTIAL
SMWM/MASS 000876

Date: 3/08/2004
Time: 4:25PM

Page: 1

SPRINGFIELD MEDICAL ASSOC INC
PO BOX 219
WINDSOR, CT 06095
Phone: (800) 883-5985

MEDICARE REMITTANCE NOTICE

Provider/Clinic#: N51714

Check No/EFT Trace No: 127340082

Date Paid: 2/26/2004

NAME:

-500

PERF	PROV.	SERVICE DATES	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PAID AMT.	
N51714		2/02/2004 2/02/2004	11	011	J9000		627.00	89.76	0.00	17.95	537.24	71.81	
N51714		2/02/2004 2/02/2004	11	011	J9070		88.00	56.43	0.00	11.29	31.57	45.14	
N51714		2/02/2004 2/02/2004	11	010	J1100		50.00	1.00	0.00	0.20	49.00	0.80	
N51714		2/02/2004 2/02/2004	11	003	J7040		36.00	16.92	0.00	3.38	19.08	13.54	
N51714		2/03/2004 2/03/2004	11	001	J2505		3688.00	2507.50	0.00	501.50	1180.50	2006.00	
N51714		2/03/2004 2/03/2004	11	001	90782		30.00	26.66	0.00	5.33	3.34	21.33	
PT Respon: 539.65							Claim Totals:	4519.00	2698.27	0.00	539.65	1820.73	2158.62

EMPLOYEE	DEPENDENT (IF APPLICABLE)	RELATIONSHIP
PROVIDER TAX ID #	PATIENT ACCOUNT #	10
042832763	091237	

87-5/840

No 1482885

01/26/2001

DATE ISSUED

REDACTED
 SHEET METAL WORKERS' NATIONAL HEALTH FUND
 P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY *****68DOLLARS AND 00CENTS** DOLLARS \$ *****68.00**

TO THE
ORDER
OF

CHARTWELL HOME THERAPIES
 DEPT L-9637

1482885

AUTHORIZED SIGNATURE

COLUMBUS, OH 43260

NON NEGOTIABLE

AUTHORIZED SIGNATURE

Subject to the Approval of
 FIRSTAR BANK, N.A.
 Bank Without Recourse
 HERETOFOR, TENNESSEE

⑈ 148 288 5⑈ ⑈ 06 40000 59⑈

293073706⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
 Goodlettsville, Tennessee 37070-1449
 Toll-Free 800-831-4914 Phone (615) 859-0131

SMW PROGRAM**EXPLANATION OF BENEFITS**

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
06/16/2000	06/22/2000	388.87	.00	68.00	68.00	68.00

NON-COVERED CODES: 388.87 .00 68.00 68.00 68.00

COMMENTS:

REDACTED

PROVIDER CHARTWELL HOME THERAPIES
 PARTICIPANT BSN
 PAB CLAIM NUMBER: 1294437

Processed by

SOUTHERN BENEFIT
ADMINISTRATORS, INC.

HIGHLY CONFIDENTIAL
 SMWMASS 001690

APPROVED UMB-0526-0006

SHEET MENTAL WORKERS NATIONAL
HEALTH FUND
P.O. BOX# 1449
GOODLETTSVILLE, TN 37070-1449

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/RS <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S ID. NUMBER (FOR PROGRAM IN ITEM 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 02-108-24 XX					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME				
5. PATIENT'S ADDRESS (No., Street) CITY: MANSFIELD STATE: NA ZIP CODE: 32048- TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Spouse <input checked="" type="checkbox"/> Other <input type="checkbox"/>				
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) CITY: ZIP CODE: TELEPHONE (INCLUDE AREA CODE)				
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (CURRENT OR PREVIOUS) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY OR GROUP NUMBER REDACTED				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED: SIGNATURE ON FILE DATE:					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: SIGNATURE ON FILE				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 150.9 MAL NEO ESOPHAGUS					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE LEROY PARKER					17a. ID. NUMBER OF REFERRING PHYSICIAN UPIN#-875955				
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 150.9 MAL NEO ESOPHAGUS					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
24. A. DATES OF SERVICE From MM DD YY To MM DD YY 06 16 00 06 22 00 06 16 00 06 22 00 06 16 00 06 22 00					20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
B. Place of Service 12					22. MEDICAD RESUBMISSION CODE ORIGINAL REF. NO.				
C. Type of Service 12					23. PRIOR AUTHORIZATION NUMBER				
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER A4221 1 A4222 1 J9190 1					E. DIAGNOSIS CODE 113 08 7 207 02 22 67 97 7				
25. FEDERAL TAX ID. NUMBER SSN EIN 042832765 XX					26. TOTAL CHARGE 300 07				
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. AMOUNT PAID 272.01				
29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) CAROLYN J. AHRENS 10/13/2000					30. BALANCE DUE 68.00				
31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) CHARTWELL HOME THERAPIES DEPT. L-9657 COLUMBUS, OH 43260-9657 (800) 445-3496					32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE CHARTWELL HOME THERAPIES DEPT. L-9657 COLUMBUS, OH 43260-9657 (800) 445-3496				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/85)
WH-04-1500-N-90 (9-85)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-80)
FORM OWCP-1530 FORM RH-1530

HIGHLY CONFIDENTIAL
SMWMASS 001691

PAGE 1

October 13, 2000

CASE #:

SHEET METAL WORKERS NATIONAL
HEALTH FUND
P.O. BOX# 1449
GOODLETTSVILLE, TN 37070-1449

PATIENT:
POLICY:
GROUP NUMBER:
POLICYHOLDER:
HOME CHEMOTHERAPY

DETAIL INVOICE

REDACTED

DATE OF SERVICE	DESCRIPTION	QTY	UNIT PRICE	EXTENSION PRICE
06/16/00 - 06/22/00	GLOVES CHEMO LG EA	4.0	3.46	13.84
06/16/00 - 06/22/00	EXT SET 12" LL (MINI)	1.0	4.40	4.40
06/16/00 - 06/22/00	DISPENSING PIN, MINI	4.0	5.85	23.40
06/16/00 - 06/22/00	CLAVE NDLESS CHTOR C-1000	2.0	9.61	19.22
06/16/00 - 06/22/00	BATTERY AA SIZE	8.0	9.73	77.84
06/16/00 - 06/22/00	COVER, STER (LCAP)	4.0	0.68	2.72
06/16/00 - 06/22/00	*** RX #: 292920 FLUOROURACIL 2655MG/180ML NS.9%	1.0	127.73	127.73
06/16/00 - 06/22/00	*** RX #: 292924 NACL 0.9%-10ML SDV	2.0	4.68	9.36
06/16/00 - 06/22/00	*** RX #: 292925 HEPARIN 100 U/ML-10ML	2.0	4.90	9.80
06/16/00 - 06/22/00	*** RX #: 292926 SYR 10CC LL	2.0	0.55	1.10
06/16/00 - 06/22/00	*** RX #: 292927 NDL, HUBER W/TUB 22GX3/4"	2.0	12.09	24.18
06/16/00 - 06/22/00	*** RX #: 292928 ACCESS KIT	2.0	37.64	75.28
*** PLEASE PAY THIS AMOUNT....				388.87

PLEASE REBIT TO: CHARTWELL HOME THERAPIES
DEPT. L-9657
COLUMBUS, OH 43260-9657
042832765

HIGHLY CONFIDENTIAL
SMWMASS 001692

United HealthCare Inc. Co
 Provider #: 0525720003
 Check/EFT #: 000000002551155

08/22/00

1-570-735-9445
 CHARTWELL HOME THERAPIES
 Page #: 004 of 005

MEDICARE
 REIMBURSEMENT

PERF PROV SERV DATE POS NOS PROC MODS BILLIED ALLOWED DEBIT COBS CMTS PROV PD

NAME 20003 0616 062200 12 A4221 207.82 207.82 0.00 41.56 OA-93 0.00 90.46
 20003 0616 062200 12 22 A4222 67.97 19.11 0.00 3.82 CO-42 48.86 166.26
 20003 0616 062200 12 7 J9190 388.87 340.01 0.00 68.00 48.86 15.29
 PT RESP 68.00 CLAIM TOTALS 388.87 340.01 0.00 68.00 48.86 272.01
 272.01 NET

NAME 0525720003 0623 062900 12 19 A4222 186.45 186.45 0.00 37.29 OA-93 0.00 90.46
 0525720003 0623 062900 12 7 J9190 67.97 19.11 0.00 3.82 CO-42 48.86 149.16
 PT RESP 63.73 CLAIM TOTALS 367.50 318.64 0.00 63.73 48.86 15.29
 254.91 NET

NAME 0525720003 0630 070600 12 7 A4221 113.08 113.08 0.00 22.62 OA-93 0.00 90.46
 0525720003 0630 070600 12 19 A4222 186.45 186.45 0.00 37.29 OA-93 0.00 149.16
 0525720003 0630 070600 12 7 J9190 67.97 19.11 0.00 3.82 CO-42 48.86 15.29
 PT RESP 63.73 CLAIM TOTALS 367.50 318.64 0.00 63.73 48.86 254.91
 254.91 NET

NAME 0525720003 0418 052100 12 4 A4221 569.08 0.00 0.00 0.00 PR-107 700.00 0.00
 0525720003 0418 052100 12 4 A4222 335.72 0.00 0.00 0.00 PR-107 569.08 0.00
 0525720003 0418 052100 12 68 J0895 5946.00 0.00 0.00 0.00 PR-107 335.79 0.00
 PT RESP 6850.87 CLAIM TOTALS 7550.87 0.00 0.00 0.00 7550.87 0.00
 CLAIM INFORMATION FORWARDED TO: ANTHEM BCBS NEW HAMPSHIRE 0.00 NET

NAME 0525720003 0522 060100 12 1 A4221 15.54 0.00 0.00 0.00 PR-107 700.00 0.00
 0525720003 0522 060100 12 11 A4222 205.94 0.00 0.00 0.00 PR-107 15.54 0.00
 0525720003 0522 060100 12 33 J0895 1189.20 0.00 0.00 0.00 PR-107 205.94 0.00
 PT RESP 1410.68 CLAIM TOTALS 2110.68 0.00 0.00 0.00 2110.68 0.00
 CLAIM INFORMATION FORWARDED TO: ANTHEM BCBS NEW HAMPSHIRE 0.00 NET

NAME 0525720003 0602 060800 12 29 A4221 392.74 0.00 0.00 0.00 PR-107 15.54 0.00
 0525720003 0602 060800 12 67 J0895 1189.20 0.00 0.00 0.00 PR-107 392.74 0.00
 PT RESP 1597.48 CLAIM TOTALS 1597.48 0.00 0.00 0.00 1597.48 0.00
 CLAIM INFORMATION FORWARDED TO: ANTHEM BCBS NEW HAMPSHIRE 0.00 NET

NAME 0525720003 0609 061500 12 21 A4221 205.94 0.00 0.00 0.00 PR-107 25.76 0.00
 0525720003 0609 061500 12 63 J0895 1189.20 0.00 0.00 0.00 PR-107 205.94 0.00
 PT RESP 1420.90 CLAIM TOTALS 1420.90 0.00 0.00 0.00 1420.90 0.00
 CLAIM INFORMATION FORWARDED TO: ANTHEM BCBS NEW HAMPSHIRE 0.00 NET

NAME 0525720003 0616 062200 12 21 A4222 244.90 0.00 0.00 0.00 PR-107 15.19 0.00
 0525720003 0616 062200 12 63 J0895 1189.20 0.00 0.00 0.00 PR-107 244.90 0.00
 0525720003 0618 061800 12 1 E0761 RRKI 700.00 0.00 0.00 0.00 CO-B17 1189.20 0.00
 PT RESP 1449.29 CLAIM TOTALS 2149.29 0.00 0.00 0.00 2149.29 0.00
 CLAIM INFORMATION FORWARDED TO: ANTHEM BCBS NEW HAMPSHIRE 0.00 NET

NAME 0525720003 0623 070900 12 3 A4221 51.68 0.00 0.00 0.00 PR-107 51.68 0.00
 0525720003 0623 070900 12 17 A4222 599.07 0.00 0.00 0.00 PR-107 599.07 0.00
 0525720003 0623 070900 12 72 J0895 2378.40 0.00 0.00 0.00 PR-107 51.68 0.00
 PT RESP 3029.15 CLAIM TOTALS 3029.15 0.00 0.00 0.00 3029.15 0.00
 CLAIM INFORMATION FORWARDED TO: ANTHEM BCBS NEW HAMPSHIRE 0.00 NET

REDACTED

Employee	
04-3477239	F207550883

20

REDACTED

06/22/2004

Date Issued

Amount Paid: \$411.04

SO WEYMOUTH, MA 02190

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Goodlettsville, TN 37070-1449

Claim No. 2554958

Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1098039

Explanation of Benefits

SMW+ Program

Dates of Service		Amount	Non-Covered	Charges Allowed	Covered	Net Paid
From	To	Charged	Covered		Net Paid	
01/07/2004	01/08/2004	\$3,510.55	\$0.00	\$411.04	\$411.04	\$411.04

Total	\$3,510.55	\$0.00	\$411.04	\$411.04	\$411.04	\$411.04
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Comments:

REDACTED

REDACTED

QUINCY MEDICAL CENTER
114 WHITWELL STREET
QUINCY, MA 02169

Provider: QUINCY MEDICAL CENTER
Participant SSN: Dependent: 01
VLC Claim Number: 2554958

Processed by



Southern Benefit
Administrators, Inc.

APPROVED OMB NO. 0535-0271

QUINCY MEDICAL CENTER 114 WHITWELL STREET QUINCY, MA 01506		2		3 PATIENT CONTROL NO. F20755088 3		4 TYPE OF BILL 831	
5A FED. TAX NO.		5B STATE TAX NO.		7 COV D.	8 NCD.	9 C/D.	10 L/R.D.
04-3477239		010704		010804	1	0	
12 PATIENT NAME				13 PATIENT ADDRESS			
				SOUTH WEYMOUTH, MA 02190			
14 BIRTHDATE	15 SEX	16 MS	21 D.H.R.	22 STAT	23 MEDICAL RECORD NO.	31	
07221923	M	W	010704	09	3	1	14 01 M0095106
15 OCCURRENCE				16 OCCURRENCE			
38 SHEET METAL WORKERS NATIONAL HEALTH FUND PO BOX 1449 GOODLETTSVILLE, TN 37070-1449				40 VALUE CODES			
42 REV. CO.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 250	PHARMACY			11	10409		
2 300	LABORATORY	86850	010204	1	6512		
3 305	LABORATORY HEMATOLOGY	85027		1	2230		
4 370	ANESTHESIA			1	46345		
5 636	DRUGS REQUIRING DETAIL	J1580		1	210		
6 730	EKG / ECG	93005		1	6289		
7							
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21							
22							
23	001 TOTAL CHARGE				353590		0
50 PAYER	51 PROVIDER NO.	52 MED. SEC. INFO.	53 PRIOR PAYMENTS	54 EST. AMOUNT DUE	55		
A MEDICARE DEDUCTED	220067	Y Y	164599	0			
B							
C							
57 DUE FROM PATIENT				0			
58 INSURED'S NAME	59 P.L.	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.			
A		0					
B							
C							
63 TREATMENT AUTHORIZATION CODES	64 EMPLOYER NAME	65 EMPLOYER LOCATION					
A	5 RETIRED						
B							
C							
67 PRIN. DIAG. CO.	68 PRIN. PROCEDURE CODE	69 DATE	70 OTHER PROCEDURE CODE	71 DATE	72 ADM. DIAG. CO.	73 E-CODE	74
60000	75261	5963					
75 P.C.	76 PRIN. PROCEDURE CODE	77 DATE	78 OTHER PROCEDURE CODE	79 DATE	80 MA53276		
9	6029	010704	A	B	B97746	KALELI, ADNAN	
					MA53276		
					B97746	KALELI, ADNAN	
84 REMARKS							
a							
b							
c							
d	MEDICARE EOP ATTACHED						

UB-R2 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

HIGHLY CONFIDENTIAL
SMWMASS 001439

220067

QUINCY MEDICAL CENTER 09/30/2004

20040518 PAGE 26

PATIENT NAME	PATIENT CNTRL NUMBER	SRV DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST	
ICN NUMBER	HC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	INSF PRI PAY	PROC CD AMT	PAT REFUND	
CLAIM #	CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PEROTEM AMT
NAME CHG=XX	HC CHG=XX	TOB=XXX	ICV LN	NCV L	COVD CHGS		INSF LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
20412501196102	F20755088 3	1040102	01	3510.55	000	1.55	0.370	1644.44	0.00	
266 11	IN0095106	1040108	01	0.00	0.00	0.00	0.00	20.87	0.00	
NAME CHG=QC	HC CHG=HN	TOB=131	01	-1.55	0.00	411.04	0.00	1455.07	0.37	
			01	3510.55		0.00	0.00	0.00	1645.99	

2nd

REDACTED